

State-administered supplementary payments.

(b) Payments under the optional supplement program must be—

(1) Based on need and paid in cash on a regular basis;

(2) Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement. Countable income is income remaining after deductions required under SSI or, at State option, more liberal deductions are made (see § 435.1006 for limitations on FFP in Medicaid expenditures for individuals receiving optional State supplements); and

(3) Available to all individuals in each classification in paragraph (a) of this section and available on a state-wide basis. However, the plan may provide for variations in the income standard by political subdivision according to cost-of-living differences.

[43 FR 45204, Sept. 29, 1978. Redesignated and amended at 58 FR 4928, Jan. 19, 1993]

§ 435.234 Individuals receiving only optional State supplements in States using more restrictive eligibility requirements than SSI and certain States using SSI criteria.

(a) In States using more restrictive eligibility requirements than SSI or in States that use SSI criteria but do not have section 1616 or 1634 agreements with the Social Security Administration for eligibility determinations, the agency may provide Medicaid to individuals specified in paragraph (b) of this section who receive only a State supplement if the State supplement meets the conditions specified in paragraph (c) of this section.

(b) The agency may provide Medicaid to all individuals receiving only State supplements if, except for their income, the individuals meet the more restrictive eligibility requirements under § 435.121 or SSI criteria, or to one or more of the following classifications of individuals who meet these criteria:

(1) All aged individuals.

(2) All blind individuals.

(3) All disabled individuals.

(4) Only aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(5) Only blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(6) Only disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(7) Individuals receiving a Federally-administered optional State supplement that meets the conditions specified in this section.

(8) Individuals in additional classifications specified by the Secretary.

(9) Reasonable groups of individuals, as specified by the State, receiving State-administered supplementary payments.

(c) Payments under the optional supplement program must be:

(1) Based on need and paid in cash on a regular basis;

(2) Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplements. Countable income is income remaining after deductions are applied. The income deductions may be more restrictive than required under SSI (see § 435.1006 for limitations on FFP in Medicaid expenditures for individuals receiving optional State supplements); and

(3) Available to all individuals in each classification in paragraph (b) of this section and available on a state-wide basis. However, the plan may provide for variations in the income standard by political subdivision according to cost-of-living differences.

[58 FR 4928, Jan. 19, 1993]

§ 435.236 Individuals in institutions who are eligible under a special income level.

(a) If the agency provides Medicaid under § 435.211 to individuals in institutions who would be eligible for AFDC, SSI, or State supplements except for their institutional status, it may also cover aged, blind, and disabled individuals in institutions who—

(1) Because of their income, would not be eligible for SSI or State supplements if they were not institutionalized; but

(2) Have income below a level specified in the plan under § 435.722. (See § 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section.)

(b) The agency may cover individuals under this section whether or not the State pays optional supplements.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980. Redesignated at 58 FR 4928, Jan. 19, 1993]

Subpart D—Optional Coverage of the Medically Needy

§ 435.300 Scope.

This subpart specifies the option for coverage of medically needy individuals.

§ 435.301 General rules.

(a) An agency may provide Medicaid to individuals specified in this subpart who:

(1) Either:

(i) Have income that meets the applicable standards in §§ 435.811 and 435.814; or

(ii) If their income is more than allowed under the standard, have incurred medical expenses at least equal to the difference between their income and the applicable income standard; and

(2) Have resources that meet the applicable standards in §§ 435.840 and 435.843.

(b) If the agency chooses this option, the following provisions apply:

(1) The agency must provide Medicaid to the following individuals who meet the requirements of paragraph (a) of this section:

(i) All pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as mandatory or optional categorically needy under subparts B or C of this part;

(ii) All individuals under 18 years of age who, except for income and resources, would be eligible for Medicaid as mandatory categorically needy under subpart B of this part;

(iii) All newborn children born on or after October 1, 1984, to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as medically needy for one year so long as the woman remains eligible and the child is a member of

the woman's household. If the woman's basis of eligibility changes to categorically needy, the child is eligible as categorically needy under § 435.117. The woman is considered to remain eligible if she meets the spend-down requirements in any consecutive budget period following the birth of the child.

(iv) Women who, while pregnant, applied for, were eligible for, and received Medicaid services as medically needy on the day that their pregnancy ends. The agency must provide medically needy eligibility to these women for an extended period following termination of pregnancy. This period extends from the last day of the pregnancy through the end of the month in which a 60-day period, beginning on the last day of pregnancy, ends. Eligibility must be provided, regardless of changes in the woman's financial circumstances that may occur within this extended period. These women are eligible for the extended period for all services under the plan that are pregnancy-related (as defined in § 440.210(c)(1) of this subchapter).

(2) The agency may provide Medicaid to any of the following groups of individuals:

(i) Individuals under age 21 (§ 435.308).

(ii) Specified relatives (§ 435.310).

(iii) Aged (§ 435.330.320 and 435.330).

(iv) Blind (§§ 435.322, 435.330 and 435.340).

(v) Disabled (§§ 435.324, 435.330, and 435.340).

(3) If the agency provides Medicaid to any individual in a group specified in paragraph (b)(2) of this section, the agency must provide Medicaid to all individuals eligible to be members of that group.

[46 FR 47986, Sept. 30, 1981, as amended at 52 FR 43072, Nov. 9, 1987; 52 FR 48438, Dec. 22, 1987; 55 FR 48609, Nov. 21, 1990; 58 FR 4929, Jan. 19, 1993]

§ 435.308 Medically needy coverage of individuals under age 21.

(a) If the agency provides Medicaid to the medically needy, it may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in paragraph (b) of this section:

(1) Who would not be covered under the mandatory medically needy group